MEDICAL REVIEW OF TEXAS

[IRO #5259]
3402 Vanshire Drive Austin, Texas 78738
Phone: 512-402-1400 FAX: 512-402-1012

NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M2-05-0151-01-SS
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	Dr. S, DC

November 12, 2004

An independent review of the above-referenced case has been completed by a medical physician board certified in neurosurgery. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

Medical Director

CLINICAL HISTORY

This now 42-year-old gentleman was injured at work on ___. At that point he was apparently pulling a heavy weight, fell backwards and hit the back of his head, his neck and his low back. Apparently there was some loss of consciousness. Following this the patient began complaining of arm pain as well as radiating leg pain. Subsequent to this he has been evaluated with a MR of his lumbar, thoracic, cervical spine as well as his brain with the most pertinent abnormalities being a protruded disc at L5 as well as a protruded disc at C5. He has also had a CT myelogram which confirms the decreased filling of his right S1 nerve root.

REQUESTED SERVICE(S)

L5 posterior lumbar interbody fusion with lateral mass fusion as well as instrumentation and a three-day stay.

DECISION

Denied.

RATIONALE/BASIS FOR DECISION

This is fairly straightforward. This gentleman, per Dr. Z's own dictation, is evidencing only a lumbar radiculopathy. It would be completely out of the standard of care to perform anything more than a lumbar laminectomy on this gentleman. Multiple nationally-recognized standards and guidelines speak directly to this. Simply address the most recent, that being the North American Spine Society's guidelines for treatment of back disorders. At this point, standard of care would point to a simple laminectomy and disc excision, but nothing beyond that point. Therefore, the requested procedure is denied.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 15th day of November, 2004.

Signature of IRO Employee: _____

Printed Name of IRO Employee: